

The Intersection of Gender, Access, and Quality of Care in Reproductive Services:

Examples from Kenya, India, and Guatemala

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Executive Summary

The 1994 International Conference on Population and Development (ICPD) in Cairo stressed the importance of gender and noted that reproductive health programs should be implemented from a gender perspective. However, little has been written about how reproductive health programs that focus on improving quality of care and access to care can integrate gender. This paper describes the experiences of three types of programs (government, reproductive health NGO, and women's health NGO) in Kenya, India, and Guatemala that integrate gender in their work and examines how they integrate gender into programs that improve quality of care and access to care. It should be emphasized that this report does not document *whether* gender integration results in higher quality and access, but rather documents *how* gender integration can take place. This report is based on data that were collected in the three countries, through interviews with a total of 27 program staff and 34 providers and through focus groups with 136 clients.

These three types of programs engage clients in the clinic and community setting in a manner closely related to their mandates and perspectives on gender. In the government and reproductive health (RH) NGOs, the emphasis is on quality and access, with gender included as a means to reach those goals. The women's NGOs have the mandate to first promote gender equity (primarily through women's empowerment), and also to use it as a means to promote reproductive health care. The organizations with the strongest internal gender policies, namely the women's and RH NGOs, are also the most committed to integrating gender into their programs for clients. The RH NGOs are most committed to gender equity or equal participation of women and men in the organization.

The Kenya, India, and Guatemala programs, in addition to some other program examples, provide a range of replicable means to integrate gender into service delivery programs. The 13 successful strategies listed below were used by the programs to integrate a gender perspective at the organizational level, within the service delivery setting, and within the community. Most of the 13 strategies come from RH NGOs and women's NGOs.

The list focuses on strategies that could be undertaken by organizations that promote and provide family planning, maternal health, and STI/HIV/AIDS services—either alone or in partnership with other organizations—and highlights gender-related activities that can complement initiatives to improve access to quality care. Clearly, these activities alone are not sufficient for promoting gender equity in societies, but they can play a part in challenging and changing gender norms and relations that are related to reproductive health.

Successful Strategies: Organizational Level

- Include gender equity (related to reproductive health) as a goal or strategy of the organization
- Adopt a gender policy for the organization that ensures equity
- Provide training in gender integration
- Employ both female and male staff and providers
- Conduct an annual program review of Quality of Care (QOC) from a gender perspective

Successful Strategies: Client Engagement Level

- Support women's needs
- Reach men with program activities
- Address gender norms when reaching young people
- Conduct counseling that includes a gender perspective
- Address gender-based violence in screening, counseling, and referral
- Create awareness of rights among women and men

Successful Strategies: Community Engagement Level

- Position reproductive health in the broader context of women's and men's lives
- Use community-based participatory learning approaches to address gender norms and roles related to family planning, reproductive health, and STI/HIV/AIDS
- Advocate for women's and men's rights

Overcoming Obstacles

Ministries of Health (MOH) provide the bulk of reproductive health services in these and many other countries, but they are often weakest at incorporating a gender perspective in their programs. Developing partnerships between ministries of health and NGOs—both health and women's NGOs—could help make public sector services more gender-sensitive. These NGOs raise awareness of rights and gender-equity issues. They could provide training to public sector providers to provide quality of care in reproductive health that integrates a gender perspective. The NGOs, which tend to be closer to the communities in which they work, could conduct gender analysis for the MOH, the findings of which could be used to improve MOH programs. Likewise, NGOs could link with the public sector when engaging in community-based participatory learning activities so that the findings of these learning activities are used to improve services for women, men, and youth, if those services are deemed to be an issue by the community.

Introduction

For the past decade, family planning and reproductive health (RH) programs have focused on improving quality of care and expanding access to care, as reinforced by the 1994 International Conference on Population and Development's (ICPD) *Programme of Action*, and USAID's Maximizing Access and Quality (MAQ) Initiative.¹ In recognition of the role that gender plays in affecting reproductive health outcomes and access to health services, ICPD also stressed that reproductive health programs should be implemented from a gender perspective.

This paper does not try to document *whether* gender integration in RH programs results in higher quality and access or to quantify the effect of gender integration, but rather focuses on *how* gender integration can take place in RH programs that focus on improving access and quality of care.² What are the approaches taken by such programs to incorporate gender? Do the approaches differ by type of program and by country?

The author describes the experiences of three types of reproductive health programs (government, reproductive health NGO, and women's health NGO) in Kenya, India, and Guatemala, and outlines the "overlap" between taking a "gender perspective," and seeking to improve "quality and access" in the programs. These experiences are offered in the hope that these insights might be instructive for other reproductive health programs in addressing gender-related barriers to access and quality of care.

Many RH program efforts have focused primarily on strengthening quality and access within service delivery settings. However, as the three types of programs in Kenya, India, and Guatemala illustrate, access barriers to services are often related to community beliefs and norms, which are deeply rooted in culturally prescribed gender roles.

These gender-related constraints to access include issues related to the following beliefs:

- ◆ That women are not able to make decisions about seeking RH services on their own;
- ◆ That women are not able to travel alone;
- ◆ That unmarried women and adolescent girls should not use RH services; and
- ◆ That men should not go to family planning or maternal and child health clinics.

Even if services are physically accessible, these gender-related constraints can result in services not being used. Quality, particularly client-provider relations, varies by the extent to which providers are sensitive to and address gender-based barriers to care.

¹ See www.maqweb.org.

² In 2004, the IGWG published the results of a review of 400 RH programs that address family planning, safe motherhood, STI/HIV/AIDS, and quality of care and found only 25 with sufficient evaluation and documentation to assess the effect of gender integration on outcomes. Only three of these programs focused on access and quality of care. The IGWG Task Force reviewing these programs concluded that integrating gender into reproductive health programs makes a difference to outcomes—both in stronger health results and in gender equity. See Boender et al., 2004

Box 1. Definitions of Access, Quality of Care, and Gender

- *Access* refers to the extent to which an appropriate package of services can be obtained by individuals in a given location (Bertrand et al., 1995). Access has several dimensions, including geographic or physical, economic, administrative, cognitive, and psychosocial.
- Although *quality* may be defined in numerous ways, the six elements introduced by Bruce and Jain capture the dimensions of quality in family planning from the client's perspective (Bruce, 1990). These elements include enabling clients to choose voluntarily among a variety of methods, providing correct information, providing services by technically competent providers, fostering good client-provider interaction, providing continuity of care, and offering an appropriate constellation of services. These components of quality care are appropriate for other components of reproductive health, including safe motherhood and HIV/AIDS, among others.
- *Gender* includes the economic, social, political, and cultural attributes, opportunities, and constraints associated with being male or female. The social definitions of what it means to be male or female vary among cultures and change over time.
- *Gender integration* implies that policies and programs take gender norms into account and compensate for gender-based inequalities that create barriers to reproductive health for men and women. Gender-based inequalities between men and women can occur through differences in roles, access to and control over resources (economic, political, legal, social, information and education, time, and mobility, internal), and in power and decisionmaking. Depending on how gender is integrated, reproductive health programs can exploit and perpetuate gender inequalities, accommodate gender differences, or transform gender relations (Boender et al., 2004).

Methods

This formative study had two main objectives: to examine current perspectives and practices in field programs regarding the integration of a gender perspective into RH programs, and how this fits with current approaches to improving “quality” and “access”; and to identify how knowledge and understanding of the concepts of quality, access, and gender may vary among different levels of program staff within a program and across RH programs.

The study was carried out in 2002 by research organizations in each of the countries, in collaboration with the POLICY Project. Study sites included Kanpur and Sultanpur districts of Uttar Pradesh in India (hereafter referred to as India/UP); in Nyanza and Nairobi districts in Kenya; and in Guatemala City, the municipal capital of Esquintla, and the municipality of Palin in Guatemala. In Kenya and Guatemala, the public sector, a reproductive health NGO, and a women’s health NGO were included in the study. The India study included two women’s health NGOs in addition to the MOH.

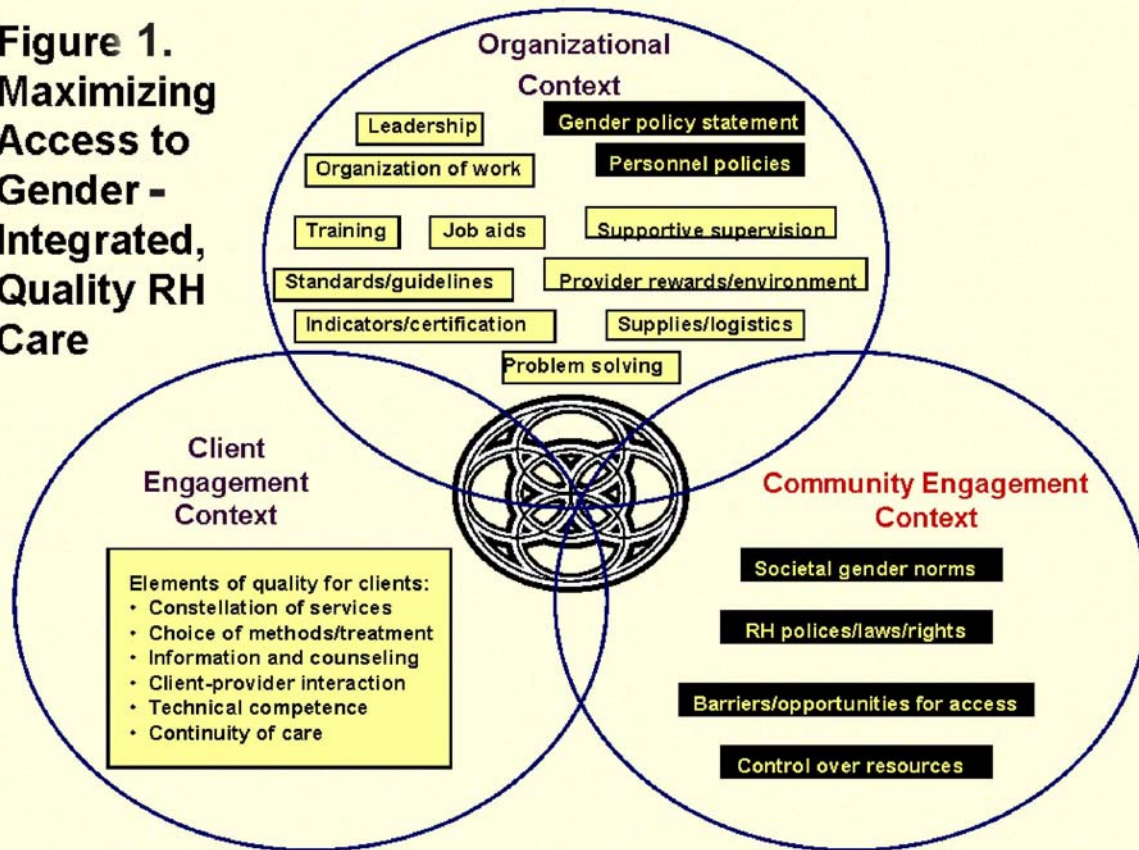
The NGO programs in India included *Shramik Bharti* (Empowering the Poor) and *Sabla* (An Empowered Woman). In Kenya, the Family Planning Association of Kenya (FPAK) and MYWO (*Maendoleo ya Wanawake* Organization, meaning Women’s Development Group) were included, and in Guatemala, the NGOs were the family planning association APROFAM and AMES (*Asociacion Mujeres en Solidaridad*, meaning Association of Women’s Solidarity).

Twenty-seven program staff (program directors, senior technical staff, and clinic supervisors), 34 providers, and 136 clients or potential clients (India included some non-users) were interviewed or participated in focus group discussions. In addition, relevant program documents were reviewed to ascertain how “quality of care,” “access,” and “gender” are characterized.

The study assessed three domains of programs: the organizational context, the client engagement context, and the community context. These domains were patterned on components of the Maximizing Access and Quality (MAQ) synergy of interventions framework needed to improve access to quality care.³ In the organizational domain, the study assessed the gender, access, and quality goals of the organization and the extent to which the organizations had gender-related equity policies. In the client engagement domain, the study addressed the components of quality of care to determine to what extent gender dimensions were included. In the community domain, the study assessed if the programs understood the gender norms and inequalities in the communities and if gender barriers were identified and addressed through program activities.

³ The MAQ Synergy of Interventions Framework (see www.maqweb.org/synergy.shtml) illustrates the importance of a synergy of interventions in efforts to improve access and quality in FP/RH programs. Implementing an intervention to address any one of the components (such as leadership, client engagement, supplies or logistics, etc.) may make a difference; however, the impact of interventions is maximized with each additional component addressed.

**Figure 1.
Maximizing
Access to
Gender -
Integrated,
Quality RH
Care**



Findings

The Community Context

Some of the barriers to quality and access in the communities are related to limitations on women's mobility, women's lack of decisionmaking power, particularly pertaining to contraception, and gender-based violence.

Women's mobility. The programs in Kenya, India, and Guatemala were situated in urban and rural areas of working class and farming communities. In these three countries, women and men have socially prescribed roles. Women are generally responsible for the home and men for outside economic activities, although the roles are changing as more women have opportunities for education and work outside the home.

In both India and rural Guatemala, women are sometimes pressured by their husband or his family not to work outside of the house. According to an MOH provider in Guatemala, *"In rural areas...machismo exists and the men pressure their women not to do any kind of work outside the home...."* Generally, men are considered dominant in decisionmaking in the three countries, although women are becoming more involved, particularly if they are educated.

Reproductive decisionmaking. Men's opinions on number of children tend to hold sway, although some women take the initiative to decide on their own, which has implications for couple communication and choice of methods. In India, the extended families and particularly mothers-in-law are closely involved in decisions on childbearing and family planning use. A Sabla provider in India/UP said, *"If we are talking about the pills then it is the women's decisions, for condoms men decide, and for copper T [IUD] and sterilization, it is the whole family's decision."* The actual use of contraception in the three countries is considered women's responsibility. Often, social pressure and gender norms prevent men from using family planning themselves. An MOH provider in Kenya explained, *"Maybe there are men who will be willing to have vasectomy. But...if they announce it they will be discouraged because in African traditions, they do not believe a man can have a vasectomy."*

Providers in the three countries acknowledged that gender norms in the community are slowly changing, due to education and exposure to various media. In India/UP, a Sabla provider noted, *"There is an increase in confidence. Women come out and attend meetings."*

Clandestine use of contraception. Providers and clients in the three countries noted that women often use contraception clandestinely, which limits communication between partners and the choice of methods a client feels she can use. An MOH provider in Guatemala noted, for example that she keeps some clients' cards with her because the clients do not want their husbands to know they are using contraception. In one particular case, the provider noted, *"One time he followed her, but she rushed in and I gave her the injection quickly."* A Sabla health worker in India said, *"So many women have pills without the knowledge of their family members."*

This clandestine use of contraception has negative implications for monitoring the quality and accessibility of programs, as it is difficult to ensure that field workers are keeping accurate

statistics. However, it is seen by some as a necessary strategy within the existing gender environment that empowers women and increases access.

Gender-based violence. In communities in all three countries, gender-based violence is acknowledged to exist and is often a barrier to accessing RH services. Providers in all three countries said clients are often reluctant to divulge its existence to others. An FPAK staff member in Kenya said, “*I think the women are over protective of their husbands and would not like to consider an outsider to know what is happening in their homes.*” An MOH manager in Guatemala also indicated that gender-based violence remains a private issue. “*It is incredible, but...there are women who say, ‘I have never been a victim of machismo’, when one knows that she is being abused...She considers that as...normal behavior.*”

Box 2. Gender, Access, and Quality of Care in the Context of HIV/AIDS

THE HIV/AIDS pandemic adds another community dimension to the issue of gender and access in reproductive health. In this era of AIDS, women may put themselves at risk for increased violence if they try to negotiate condom use. Program staff might be able to reduce this risk by reaching men directly rather than expecting women, who face many facets of gender inequity in their lives and relationships, to negotiate with their male partners on an individual basis without any outside assistance. AIDS comes up in counseling in each of the countries, but the messages reach mostly women since nearly 95 percent of clients are women. A Sabla provider in India/UP, however, indicated that counselors bring up the topic of AIDS to both women and men, saying, “*We tell her about AIDS, we tell them that you are bringing it from Delhi or Bombay from the red light area there and give it to your wife here. When we have the couple meet we tell them or when we talk to the women we ask them whose husband has to go out for work...*”

The Organizational Context

Gender, access, and quality are stressed to differing degrees by the three types of organizations (see Table 1). In the governmental organizations and the reproductive health NGOs, the emphasis is on quality and access, with gender included as a means to reach those goals. The women’s NGOs have the mandate to promote gender equity in and of itself, and also use it as a means to promote reproductive health.

Guatemala has national legislation and policy that dictates integration of gender into reproductive health. However, according to Nunez de Rodas (2003), in practice, “*it is assumed that it is in force and that its application is generalized, but there are no known strategies or precise guidelines for its implementation.*” According to an MOH staff member in Guatemala, having a law or policy is not sufficient to assure that gender will be integrated into programs.

Table 1 Inclusion of Quality, Access, and Gender in Organizational Goals in Three Types of RH Programs				
Organi- zation	MOH	RH NGO	Women's NGO	
Kenya	Reduce unmet need for family planning by making quality and sustainable services available to all. Eliminate discrimination against women and increase male participation .	Make RH services available to the underprivileged. Focus on quality and gender issues.	Focus on gender equity . Increase status and condition of lives of community members by increasing access to quality RH services.	
Guatemala	Government policy to integrate gender perspective into services. Focus on providing quality clinical care.	Provide sexual and RH care, focusing on gender and quality , to the poor.	Focus on gender equity in the economic, social, and cultural development of women through human, labor, and health rights; provide RH care; access for <i>maquilas</i> (garment workers).	
India	Provide quality of care for community at clinics. Remove access barriers through outreach/camps.	NA	Focus on gender justice and empowerment of women . Expand people's choices and increase economic participation. Improve access to employment, credit, health, and education.	Reach poor women (and men) to improve FP provision and address related gender-equity issues.

Gender Policies of the Organizations. One of the main objectives of this study was to identify how knowledge and understanding of the concepts of quality, access, and gender may vary among different levels of program staff within a program and across RH programs, given that knowledge of gender and incorporating it “at home” is essential if the organizations are going to be able to overcome gender barriers in their work.

Some of the organizations have explicit gender-equity policies for staff (see Table 2).⁴ Among the ministries of health in the three countries, only the MOH in Guatemala has a policy to promote equity, although it is not necessarily carried through in practice in the ministry. According to one MOH staff member, in her area, “*We have more or less 80% women; however,*

⁴ It should be noted that gender integration within organizational policies and structures is important from a rights and social justice perspective. However, the author and task force members know of no research to date clearly demonstrating that the implementation of gender-equitable policies within organizations improves access and quality of services.

about 90% of the managerial positions are occupied by men, and this is due mainly to the fact that men have more opportunities to finish university careers than women do.” In India, most senior staff in the ministry are men. In Kenya, the staffing in the MOH is mixed. Study participants from Kenya noted that, while many top-level staff are women, district level leaders tend to be men.

The two reproductive health NGOs included in the study are affiliates of the International Planned Parenthood Federation (IPPF), which strongly promotes gender equity within the federation (IPPF/WHO, 2000). A participant from APROFAM in Guatemala noted, *“Yes, there is a policy [that promotes gender equity] that not only exists within the structure of the organization, but which also reaches the political level.”* Both NGOs have policies to ensure that half of the top leadership (including the board of directors and the executive staff) is female and half is male. A staff member explained that FPAK, *“has a very solid policy stipulated in our policy documents.... There is a provision of 50% of all the policymakers to be women....”* FPAK has also made strides in hiring some male nurses for its clinics, and more of its peer youth educators are male than female (gender educators, on the other hand, mostly are female).

All of the women’s NGOs have clear policies ensuring that women predominate in management positions. As stated by a MYWO staff member in Kenya, *“The practice in place is to ensure that men do not take over the organization.”* Women form the top leadership in Sabla in India/UP. One staff member explained that, *“Sabla means ‘an empowered woman,’ so leadership has to be from women.”* For its outreach work, however, Sabla has a policy of 50-50 recruitment of women and men—a practice that is against its funding agency’s guidance to only hire female outreach workers. Sabla insists on adhering to the 50-50 policy because it is the only way the organization can reach both women and men given the cultural taboo on women reaching men (and vice versa) with family planning, reproductive health, and safer sex messages.

Table 2 Gender-related Policies for Staffing in Three Types of RH Programs				
Organi- zation	MOH	RH NGO	Women's NGO	
Kenya	<ul style="list-style-type: none"> • None • Many top central-level staff are women; district leaders male 	<ul style="list-style-type: none"> • Promotes equity • 50-50 representation in leadership 	<ul style="list-style-type: none"> • Promotes equity • All senior management are women 	
Guatemala	<ul style="list-style-type: none"> • The government promotes equity; doesn't necessarily translate into ministry actions • Top management mixed 	<ul style="list-style-type: none"> • Promotes equity • 50-50 representation in leadership 	<ul style="list-style-type: none"> • Promotes equity • Director and 90% staff are women 	
India	<ul style="list-style-type: none"> • None • Many top staff men 	<ul style="list-style-type: none"> • NA 	<ul style="list-style-type: none"> • Promotes equity • Currently 3 men, 4 women on the board • Women given preference at all levels 	<ul style="list-style-type: none"> • Promotes equity • Women leaders • Field staff 50-50

The Client and Community Engagement Context

As is common throughout the world, most people reached through the services in the three countries are women. With the exception of Sabla in India/UP, whose program is designed to reach both women and men, fewer than 5 to 10 percent of clients are men. Few couples are reached, although the programs try to encourage couples to attend, especially new clients, those with STIs, and those seeking permanent contraception.

How the three types of programs engage clients within clinics and the community is closely related to their mandates and perspective on gender (see Table 3). From one perspective, reproductive health is considered a means to promote gender equity (or improve the status of women) while from the other perspective, reproductive health is a service to include within a wider developmental approach to promoting gender equity. The MOH programs are more likely to be clinic-based; only India has outreach workers. While the ministries of health acknowledge that gender issues affect reproductive health, they do little in their clinic-based services to address gender inequities.

The reproductive health NGOs are partly clinic-based and partly community-based; in both settings, gender inequity in the community is acknowledged and addressed. The women's NGOs have a clear mandate to address gender inequity; thus RH and HIV/AIDS information is offered as one of a range of activities to improve gender equity—primarily through women's empowerment activities. For example, in each country the women's NGOs are working to provide women with the skills and resources to engage in economic activities, through microcredit groups and income-generation activities, among other activities.

Table 3
Community Engagement in Three Types of RH Programs

Organization	MOH	RH NGO	Women's NGO	
Kenya	<ul style="list-style-type: none"> • Promotes gender equity and reproductive rights but works through health centers • Few men or youth reached 	<ul style="list-style-type: none"> • Provides clinic services • Outreach through volunteers attached to health centers • Previous focus on reaching men • Current focus on reaching youth 	<ul style="list-style-type: none"> • Trains women in income-generation activities and other topics • Outreach through community-based workers and referral for RH services • Community-based RH service providers provide contraceptives, home-based care, awareness of family planning and HIV/AIDS • Includes outreach to men and youth 	
Guatemala	<ul style="list-style-type: none"> • Country has laws stressing gender equity; MOH has no community-based program to promote equity • Clinic-based services • Few men or youth reached 	<ul style="list-style-type: none"> • Provides clinic services • Outreach to families 	<ul style="list-style-type: none"> • Committed to achieving the development of women • Nutrition, energy and environment, civic education, training in income generation and decisionmaking • Outreach through community promoters for health and referral for RH services • Includes some outreach to men and youth 	
India	<ul style="list-style-type: none"> • Provides clinic services, primarily to women • Few men or youth reached • Outreach workers focus on reproductive health 	<ul style="list-style-type: none"> • NA 	<ul style="list-style-type: none"> • Microcredit groups, etc. • Awareness on rights • Gender advocacy • Outreach through community-based workers and referral for RH services • Meet women's practical needs through reproductive health and strategic needs through livelihoods • Few men reached • Difficult to reach youth 	<ul style="list-style-type: none"> • Community engagement to address gender equity • Outreach through a couple approach—emphasis on reaching women and men; get couples together to build an understanding • Family orientation; get parents and adolescents together • Family dispute counseling • Short-stay home for domestic violence • Outreach through community-based workers and referral for RH services • Outreach workers provide some contraceptives

Program Activities to Integrate Gender With Access and Quality of Care

The programs reviewed in Kenya, India, and Guatemala—particularly women’s and reproductive health NGOs—are using a number of strategies to integrate gender into their organizations and program activities to improve access and quality of care. These strategies have been organized under the headings of organizational, client engagement, and community engagement contexts; in fact they are not mutually exclusive. Strategies used in one context reinforce those used in another context. For example, the gender policies of an organization influence the programs the organization supports. The client and community engagement contexts particularly overlap.

Successful Strategies: Organizational Context

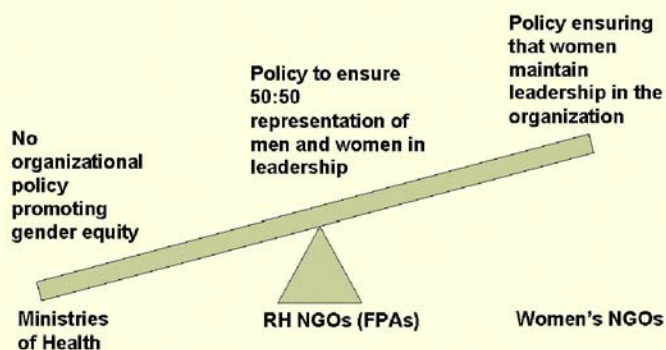
■ **Include Addressing Gender Equity (Related to Reproductive Health) as a Goal or Strategy of the Organization**

While including gender equity as a goal or strategy of an organization is certainly a starting point, it is not sufficient for ensuring that gender is integrated in programs. All of the organizations included gender in their statement of goals (see Table 1). The women’s NGOs made the strongest statements about transforming gender relations through their programs (by promoting gender equity through women’s empowerment). Women’s NGOs consider ensuring access to quality RH care as one of the means of empowering women. The RH NGOs (both IPPF-affiliates) take the view that gender equity means also working with men, although that principle is manifest more within the organizations than in reaching men as clients. Although the ministries of health in two countries include “gender” in their goals or strategies, in practice, few activities relate to seeking to integrate gender.

■ **Have a Gender Policy That Guides the Organization and Translates into Services**

At the policy level, the organizations exhibit a continuum of policies regarding gender equity both in programs and within the organization—from no policy to policies that ensure women maintain leadership in the organization (see Figure 2). Ministry of Health policies and language on gender, where they exist, do not always lead to internal gender-equity initiatives for staff. Women’s NGOs that promote gender equity in their programs also have organizational policies to ensure that women remain as leaders of the organizations. The family planning associations in Kenya and Guatemala subscribe to IPPF’s clear mandate for 50-50 representation of women and men in senior management, making these organizations, in fact, the most gender-equitable. In terms of reaching both women and men, the women’s NGO Sabla in India/UP perhaps has the most balanced approach since it insists on a balance of male and female workers.

Figure 2. Organizational Adherence to Gender Equity



Among the three types of organizations included in the study, the organizations that explicitly addressed gender considerations in organizational policies had more success in creating programs that incorporated gender equality. The organizations with the strongest internal gender policies appear to be the most committed to integrating gender into their programs for clients. The IPPF affiliates have the most equitable gender policies. Other RH organizations that wish to improve reproductive health while simultaneously promoting gender equity can follow IPPF's lead in institutionalizing gender—both within the organization and in programs for clients (Ortiz-Ortega and Helzner, 2003; IPPF/WHO, 2000; IPPF/WHO, 2002). Management Sciences for Health has also devoted an issue of *The Manager* to managing RH services with a gender perspective (MSH, 2000).

■ Provide Training in Gender Integration

Organizations that are committed to integrating a gender perspective in their programs also generally devote resources to training staff concerning gender issues in reproductive health. The training may include information sharing, awareness, and skills-building. An APROFAM staff member in Guatemala said, “*We refresh our knowledge on contraceptive methods, on violence against women... and we bring international trainers to teach us about gender ... We are in constant training.*”

A number of providers and staff members from RH and women's NGOs noted the value of including gender in training on quality of care and vice versa. Each of the RH and women's NGOs has gender specialists who are very knowledgeable about gender issues in their communities. Those specialists could collaborate with experts in quality of care to develop and provide training not only for their own organizations but also for public, private, and NGO organizations providing family planning, reproductive health, and STI/HIV services. FHI has produced a training manual for health care providers titled, “Rethinking Differences and Rights in Sexual and Reproductive Health” (Paulson, Gisbert, and Quiton, 1999).

■ Employ Female and Male Staff and Providers

Among the nine programs reviewed in the three countries, only the women's NGO Sabla in India/UP employs a significant number of male outreach workers to reach men in the community. Although no quantitative data were offered, a Sabla staff member said that outreach is more effective in the areas using the couples approach to community-based development. One drawback to this program is that there is no extra remuneration for the male workers. The couple receives a joint salary.

A few MOH health centers in India also employ male auxiliary nurse midwives in order to reach men. The male outreach workers can adapt their work schedules to meet men in the community at convenient times when the men are not working, such as in the evenings and on weekends.

FPAK's gender educators are mostly women, who, according to an FPAK provider, “*try to address specific issues, e.g., FGM in Nyambene and...early marriage in Kilifi—having the gender educators to train the parents of these children to be retained in school.*” The addition of male gender educators could help the program reach men with important messages on gender and reproductive health.

■ Monitor QOC in Programs From a Gender Perspective

The RH NGO in Guatemala has used the International Planned Parenthood Federation's (IPPF/WHR) manual on addressing quality of care from a gender perspective. The manual includes an evaluation component that family planning associations can implement periodically to assess their programs' efforts in gender equity and access and quality of services. APROFAM uses this assessment tool in Guatemala and, according to a staff member, "...we evaluate the quality of the services based on gender once a year." IPPF/WHR has also developed a gender continuum (from "not at all" to "somewhat" to "ideal" gender-sensitive programs) to help program managers ascertain how gender sensitive their HIV and family planning programs are (IPPF/WHR, 2002).

Successful Strategies: Client Engagement

■ Support Women's Needs

Providers need to support women's particular needs in accessing services and in quality of care. This may be through supporting women's need for clandestine use of contraceptives (which may be disagreeable to those who view this as accommodating gender norms rather than challenging them) or through tailoring clinic settings for women (e.g., female staff and times that women can access the clinics).

■ Reach Men With Program Activities

Providers in the three countries agreed that men need to be more integrally involved in RH programs to truly address gender issues. Not only are men often the gatekeepers and decisionmakers within their families, but they have an important role to play as supporters of female partners and as potential users themselves of RH services and family planning specifically. Like most family planning and RH programs around the world, eight of the nine programs included in this study overwhelmingly reach women. An MOH staff member in India/UP said, "*We should have some policy.... Our policy, at present, does not deal with [men] at all.*" Staff and providers in each of the countries remarked that family planning has long been considered a women's issue for which men have not been expected to take much responsibility.

Similarly, gender is considered by many to be a women's issue that somehow does not involve men, a point confirmed by a FPAK staff member and an MOH provider from Guatemala. Another provider in Guatemala said, "*I believe that we must continue working on [women's] empowerment, but if men are put aside, this is not going to improve.*"

Moreover, the existing literature makes clear that if men are not involved in family planning it puts more of the onus on women (who really have no "power" in the relationships) to do the negotiating, and it ultimately leaves men's RH needs unmet.

Encouraging couple communication and involving men in more meaningful ways reduces women's need to use family planning methods clandestinely (IGWG, 2003; Haberland and Measham, 2002). Evidence from programs in Ghana (Navrongo) and Peru (ReproSalud) that incorporated gender showed that involving both women and men in program activities led to more effective RH outcomes than outreach to only men or to only women (Schuler, 1999; Rogow, 2000. See also IGWG, 2003).

■ Address Gender Norms When Reaching Young People

Gender and societal norms often put young people at increased risk when it comes to sexual and reproductive health issues, particularly when it comes to accessing RH services. Generally, girls and young women are expected to be ignorant of any sexual or RH knowledge and, therefore, are hesitant to ask questions. Norms of masculinity often encourage boys and young men to act recklessly and without taking precautions (HORIZONS, 2004). These norms can keep young people from accessing RH services, even where legislation stipulates access, such as in Kenya. MOH staff in Guatemala and India both said young girls are only given access when they are already pregnant.

In all three countries, providers noted that young people need information and services before they begin sexual activity in order to make responsible and healthy choices. A provider from Guatemala noted the need to particularly work with young men to change the way they interact with young women regarding relationships and sex. FPAK is the only organization studied that has youth as its focus, with centers for out-of-school youth for both young women and young men. In addition to information and services for reproductive health, FPAK holds classes to give young people skills, such as sewing, and collaborates with the Kenya Library Service to provide books to young people.

To break the cycle of gender inequality and its effects on RH outcomes will require working with young females and males to shift the norms and roles to promote equity in status, power, and resources (IGWG, 2003).

■ Conduct Counseling That Includes a Gender Perspective

Counseling that includes a gender perspective involves talking to clients about their lives and their relationships. A provider from FPAK explained how they integrate gender into their counseling and services in Kenya:

“We try to empower women with information and skills so that they can make informed decisions, they can be prepared to change the situation they are in ...by making them identify the potentials they have in them and trying to make them feel as equal partners with men in development and reproductive health. We also empower them so that they can negotiate for safer sex practices. Because...you should be able to discuss condom use and why it is important. If the man does not want to use the condom you should be assertive enough to say that it is even for the married. We also empower the young people to say ‘no’ to advances in unsafe sex.”

A provider from APROFAM in Guatemala described their gender-sensitive counseling approach:

“After we start the questions to gather information for healthy family planning, we talk a little about their personal lives. ‘How long have you lived with your husband? How are you?’ This is all done to gain their confidence; otherwise they will not tell us about their lives; they are not ready.... Suddenly we see a bruise, a small wound, ‘What happened? Do you have problems in your home?’ Then we start talking about the gender-based violence program. Sometimes women come

because they suffer from a sexually transmitted disease.... [We ask,] ‘Have you had medical exams? Gynecology exams? An AIDS test?’ ... These are questions which bring us closer to their private lives to get to know them better and to understand women’s problems more accurately.”

APROFAM clients in the focus group confirmed that APROFAM staff asked about their relationships with their partners and about STIs during counseling.

APROFAM in Guatemala also educates “teenagers on sexual education, stage by stage, to make them value and know themselves, to teach them about the physical and emotional changes, and about making responsible decisions... We even have a program that includes the use of mechanical babies, to see how prepared they are to become responsible parents.”

■ Address Gender-based Violence in Screening, Counseling, and Referral

Gender-based violence (GBV) came up in each of the country studies, although, with the exception of the RH NGO program in Guatemala, the programs do not have systematic strategies to address GBV systematically. The often hidden issue of GBV can have important implications for decisions about fertility, contraception, and partner negotiation of condom use to protect against the transmission of STIs and HIV/AIDS.

Most providers in the programs do not seek out information from clients on violence. APROFAM in Guatemala is an exception—it has an IPPF program that operates in some clinics to detect violence.

“The program consists of the doctor asking openly three or four questions of the patients. He or she asks them if they have suffered some kind of violence in their homes. If this violence has been physical, verbal or psychological and whether or not they suffered any sexual abuse when they were young or during childhood. Later on, when a violence victim is detected, she is immediately referred to a group of ladies who take care of such matters...so that they can talk. Right now we are in the process of forming a support group with these women... We acquaint this group of women with different organizations that can help them, even when they want to file suit. Anyway, this program is directed to their devising an escape plan when they think they need it.”

AMES in Guatemala also deals with gender-based violence in its programs, mostly by referring to other organizations that are better equipped to handle abuse cases. In India/UP, a staff member from *Shramik Bharti* noted, “When we suspect that a woman is being beaten, then we try to persuade them for a family or couple discussion.” A Sabla staff member in India said, “...we also tell [the men] that women also have many rights and if she complains to the police then the husband will be ...punished.”

Community-based programs have effectively addressed GBV by communicating directly with the men and families involved. Programs can provide training for staff on recognizing GBV and providing appropriate counseling and referral for help. Addressing GBV through clinical and

community-based approaches and through the media has been effective in reducing GBV and improving RH outcomes (IGWG, 2002a).

■ Create Awareness of Rights Among Women and Men

Many staff members and providers noted the need to educate women and men about their rights if they are going to be able to break down barriers to accessing reproductive health. An AMES staff member in Guatemala noted they are training providers on *“women’s and young people’s sexual and reproductive rights.”* A provider in the Ministry of Health in Guatemala said, *“We try to make [women] see that they [including victims of gender-based violence in the home or at work] have working rights.”* However, an APROFAM provider from Guatemala said that, *“To [get women to] start thinking that they also have rights [is a challenge].”*

An FPAK provider in Kenya said, *“...if [women] are not empowered to know their rights then I don’t think we can develop. To me...it is a key priority.”* An MOH provider in Kenya noted that as awareness of rights increases, gender roles are changing. *“...more women have been educated and they know their rights. So it is because of more awareness [that gender roles are starting to change].”*

Successful Strategies: Community Engagement

■ Position RH Within Broader Needs in Women’s and Men’s Lives

While ministries of health generally focus on providing clinical services, the RH and women’s NGOs often take a broader view of reproductive health care, providing activities in the community that meet reproductive health care needs and promote transformation of gender relations. This can have an impact on women’s economic empowerment, which elevates their status in the family and can lead to more involvement in decisionmaking, including decisions about RH care. As one FPAK staff member in Kenya noted:

“There is a need to promote inter-partner communication on reproductive health issues as one way of countering [barriers to access to services and]...to address the traditional beliefs and practices which happen in our communities like, for example, the belief that a girl should be married and not go to school. There is also need to address economic barriers. [E]conomic empowerment.... will enable one to make decisions.”

MYWO in Kenya provides income-generation activities to empower women economically as a means of transforming gender relations. A MYWO staff member said:

“The field workers in MYWO train women in income-generation activities. Women are given empowerment to get involved in decisionmaking. This makes them gain recognition. We are empowering girls to gain education at least up to form 4 to take charge and change the power relations.... The CBDs have started groups at the district level. Now there is a revolving fund operating at the district level...to empower them economically.”

In India, a staff member from Sabla explained, *“...if a woman starts earning even 200 rupees she gets some importance in her family, there is no doubt about it.”*

Many staff members and providers noted the confidence women gain from wide-ranging programs that provide women with economic resources and teach them about their rights. Such programs—especially if they also reach men—can help women to negotiate safer sex practices and give women life skills to make informed decisions about their bodies and their families (Boender et al., 2004). While RH programs cannot be expected to also provide education, program staff can encourage parents to keep their children—and particularly their daughters—in school.

Understanding the gender dynamics of the communities in which programs and services are situated is key to meeting the needs of women and men.⁵ For example, drawing on lessons it has learned working in rural areas, Sabla now insists on using both female and male outreach workers, because, according to one staffer, “the woman is not so powerful to be able to convince everyone in the family.”

Gender analysis of a community can also be used to assess quality of care—by comparing how providers treat women and men differently and how women and men experience services differently (Matamala, 1998). Several good sources exist on conducting a gender analysis and on integrating gender into reproductive health and HIV/AIDS programs.⁶

■ Use Community-Based Participatory Learning Approaches (PLA) to Address Gender Norms and Roles

Participatory learning approaches (also known as community learning approaches) can help improve access through improved couple communication about the need for FP/RH and womens’ ability to access services. Moreover, as parents understand their children’s needs for information on reproductive health, they will be more likely to discuss these issues with their children and adolescents. Thereafter, young people may feel more empowered to seek the information and services they need. Sabla has used a community learning approach that promotes full participation of people in the processes of learning about their needs and opportunities, and in the action required to address them. Sabla has used this approach in bringing husbands and wives and parents and children together to improve communication.

Regarding working with husbands and wives, a Sabla staff member in India said, “*Some of them were married for 25 years but they didn’t know what [each other liked]. ... [In discussion we] told them how they have distances between them, they are living together but they are far away from each other.*” Based on this approach, couples began to talk about issues such as number of children to have, family planning use, and other issues.

In Sabla’s mother-daughter meetings and father-son meetings, “*We have an activity for mother and daughter, through this we tell that what the mother felt when she was the daughter’s age. So now she can understand very well what the daughter is going through and her needs.*”

Use of participatory learning approaches is becoming more common in RH and HIV/AIDS

⁵ See also Vlassoff and Moreno, 2002; Pittman and Hartigan, 1996; IGWG, 2000.

⁶ See Caro et al., 2003. See also www.gdrc.org/gender/framework/g-framework.html.

programs, for example, through use of Stepping Stones, a community training methodology on HIV/AIDS and communication, and relationship skills, with a strong reproductive health and gender-equity component.⁷ Various participatory learning approaches exist.⁸

■ Advocate for Women's and Men's Rights

In addition to creating an awareness of rights among clients, women's and reproductive health NGOs can and do play a role in advocating for the equal rights and empowerment of women. FPAK and APROFAM both said they consider this role important. APROFAM particularly focuses on advocacy issues and gender-based violence. "...We are important at a national level," a staffer said, "...as an institution [to] show the people that violence against women exists, and this could work out as a basis for the government to develop some policies in which they can introduce the service for protection against gender-based violence." Raising awareness of rights violations can help turn a spotlight on aspects of programs that need to be strengthened to ensure access and quality.

⁷ Welbourn, 1995; Welbourn, 1999; and www.actionaid.org/stratshope/ssinfo.html

⁸ See www.iac.wur.nl/ppme/content.php?ID=394&IDsub=571.

Conclusion

Many program efforts have focused primarily on strengthening quality and access within service delivery settings. However, as the three types of programs in Kenya, India, and Guatemala illustrate, access barriers to services are often related to community beliefs and norms, which are deeply rooted in culturally prescribed gender roles.

These gender-related constraints to access include issues related to the following beliefs:

- ◆ Women not being able to make decisions about seeking RH services on their own;
- ◆ Women not being able to travel alone;
- ◆ Unmarried women and adolescent girls should not use RH services; and
- ◆ Men should not go to family planning or maternal and child health clinics.

Even if services are physically accessible, these gender-related constraints can result in services not being used. Quality, particularly client-provider relations, varies by the extent to which providers are sensitive to and address gender-based barriers to care.

While ministries of health provide the bulk of RH services in many other countries, ministries of health are often weakest at incorporating a gender perspective in their programs. Developing partnerships between ministries of health and NGOs—both health and women’s NGOs—could help make public sector services more gender-sensitive. These NGOs are often able to raise awareness of rights and gender-equity issues. They could provide training to public sector providers to provide quality of care in reproductive health that integrates a gender perspective. The NGOs, which tend to be closer to the communities in which they work, could conduct gender analyses for the MOH, and the findings of these analyses could be used to improve MOH programs. Likewise, NGOs could link with the public sector when engaging in community-based participatory learning activities so that the findings of these activities could be used to improve services for women, men, and youth.

As an MOH provider in Guatemala said, *“The quality of the services has improved; however, I think there is still much to do, and we are going to achieve it, not only with the Ministry of Health, but by coordinating and joining together governmental and nongovernmental organizations that can influence the various areas [related to gender]...”*

The findings from the programs in Kenya, India, and Guatemala, in addition to other program examples, provide replicable examples of a range of ways to integrate gender into programs to improve access to quality services—both within the service delivery setting and through community outreach that promotes gender-equitable interaction with women and men.

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